# CONTRACT MEDICAL SERVICES

## HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

## COMMITTEE ON VETERANS' AFFAIRS
## HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

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July 29, 1987

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Printed for the use of the Committee on Veterans' Affairs

**Serial No. 100-23**

U.S. GOVERNMENT PRINTING OFFICE
77-309 ⇆ WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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# CONTRACT MEDICAL SERVICES

Wednesday, July 29, 1987

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 1:34 p.m., in room 340, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Stump and Dornan.

## OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. The hearing will come to order. Thank you for waiting. I'm sorry that the previous vote kept me a little longer than I anticipated. We want to welcome you and wish you a good afternoon.

The subject of our hearing today is contract medical services. Under current law, the VA may contract with health care providers to purchase needed medical services. By using contracts, VA medical centers are able to purchase services which they otherwise might not be able to obtain. If a VA medical center cannot recruit or retain personnel needed to provide a particular service, that service can be purchased by contract. Contracts for purchasing medical services are clearly an important resource.

The cost of medical services purchased by a contract can also be very significant. According to the VA Inspector General, last fiscal year nearly $53 million was spent to acquire resources through scarce medical specialist contracts and sharing agreements. Based on the results of a recent survey conducted by the committee, more than $62 million was spent by the VA medical centers last fiscal year to purchase contract medical specialty services.

Several previous routine audits issued by the Inspector General have addressed the subject of contract medical services. More recently, the IG issued a summary audit on this subject, as well. These audits suggest not all contracts for medical services have been negotiated, administered, or used wisely. These audits contain a number of disturbing findings, and they indicate the possible waste of substantial resources. According to the audits, contracts have been negotiated and administered by persons who had a personal financial interest in the contract. Contractors have received payment for services which they did not provide. Contractors used overstated costs in pricing data to justify inflated and excessive contract costs. More services were purchased than were needed.

And finally, no internal controls were established to ensure proper contract negotiation and administration.

Again and again, these audits indicate changes are needed in contracting for medical service. The status quo is not acceptable to this committee, particularly given the deficit problems that we face.

The contracts which have been reviewed by the IG are agreements between a VA medical center and an affiliated medical college or associated institution. The purpose of this hearing is not to examine the potential value of a particular affiliation, or affiliation in general. Affiliation is not the subject of this hearing. The subject of this hearing is the medical service contracts; the nature of contract agreements, the contracting process, and how contracts are administered.

In addition, we want to learn what corrective actions have been recommended and can be taken. What can and should be done to ensure that resources are used more wisely and efficiently in the future?

[The prepared statement of Chairman Evans appears on p. 31.]

Mr. EVANS. Before calling our first witnesses today I am happy to recognize Congressman Bob Stump, the ranking minority member of our subcommittee, for any comments that he may wish to make at this time. Mr. Stump.

## OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman.

I am pleased that you have taken the lead in looking into this most troubling situation. To ensure that our veterans have the best possible health care available, Congress has provided the Veterans' Administration with the authority to contract for certain types of health care services. However, this authority is not a license to overcharge the medical centers. Contract abuses at the VA medical centers shortchange our Nation's veterans. This simply will not be tolerated by this committee, by the full committee, or by the Congress.

I am pleased that the VA is looking into it in a timely manner to implement corrective action, but our committee will continue to monitor these activities.

Thank you. Mr. Chairman.

Mr. EVANS. Thank you, and I appreciate your continuing leadership and interest in this issue as well.

Our first witness today is Mr. Ken Furukawa, the Assistant Inspector General for Auditing, the Veterans' Administration Inspector General's Office. He is accompanied by Mr. Renald Morani, the Deputy Inspector General, and Mr. Michael Slachta, the Deputy Assistant Inspector General for Headquarters Audits. If they could come forward now, we would like them to be seated.

We want to welcome you to the subcommittee this afternoon. Ken, I understand this is your first appearance before the committee as a witness. We're glad you're here, and we're looking forward to receiving your testimony. I also want to thank you for the timely submission of your written testimony. Your prepared statement has been submitted, and without objection, will appear in its

entirety in the record, so you are free to summarize from that or proceed in any manner that you wish. We thank you again for your appearing before us today.

**STATEMENT OF KENNETH T. FURUKAWA, ASSISTANT INSPECTOR GENERAL FOR AUDITING, VETERANS' ADMINISTRATION; ACCOMPANIED BY MICHAEL SLACHTA, JR., DEPUTY ASSISTANT INSPECTOR GENERAL FOR HEADQUARTERS AUDITS**

Mr. FURUKAWA. Thank you very much, Mr. Chairman. Accompanying me is Mr. Michael Slachta, my Deputy for Headquarters Audits. I must apologize for Mr. Ren Morani, our Deputy Inspector General. He had a conflict in his schedule and is unable to make it today.

I would like to just briefly summarize my prepared statement.

Mr. Chairman, members of the subcommittee, I am pleased to be here today to discuss the results of our audits that reported on the VA's process of obtaining and providing medical services through contracts with affiliated medical schools.

Our normal audit process requires a review of all VA health care facilities on a 3-year cycle. Audits of VA medical centers are necessarily limited by available audit resources. As a result, we are not able to review all VA services and functions during each cyclical audit. Since sharing agreements and scarce medical services contracts are not a major resource issue at most VA medical centers, these contracts are not routinely subject to cyclical audit. However, during the past 2½ years, we have issued six medical center audit reports that contain findings regarding the VA's purchase of medical resources from affiliated universities. In total, these six medical centers paid approximately $3.7 million for services for which we estimated the cost could be reduced by approximately $1.7 million through improvements in the contract award and contract administration process.

In order to assure that the Chief Medical Director was aware of our findings in these cyclical audits and of the potential for developing an agency-wide problem, we recently summarized our findings and made recommendations to improve overall accountability. Our summary audit detailed the following issues.

Contracts were entered into for some anesthesiology and radiology services that were not needed.

VA medical centers paid for some services that were not provided in accordance with contract terms.

Controls had not been established to ensure that services were required and that contractor performance and billings complied with contract terms.

In addition, DM&S had not adequately developed a system for evaluating and monitoring the award of these contracts.

We have made a number of recommendations associated with these conditions. The Chief Medical Director concurred with our recommendations and indicated that the Department will publish a circular by the end of August, 1987, which will request the field facilities send in to the VA Central Office for review all renewed Scarce Medical Services contracts. In addition, DM&S plans to complete studies to develop contract parameters for anesthesiologists

and radiologists by September, 1988 and September, 1989 respectively.

According to the Chief Medical Director, these actions will enable the Department to develop a relationship between workload and FTEE requirements.

The planned actions are responsive to our recommendations, and thus we consider all the audit issues to be resolved.

This concludes my testimony, Mr. Chairman. I will be pleased to respond to any questions that you may have.

[The prepared statement of Mr. Furukawa appears on p. 35.]

Mr. EVANS. Thank you very much.

According to the recent IG summary audit, in 1977 the VA's internal audit service concluded that "the VA Central Office needed to improve its process for evaluating and approving contracts proposed by medical centers. Specifically, the audit found that the Central Office had not established specific criteria for evaluating the costs versus benefits of contract proposals." Today in 1987, 10 years later, have those inadequacies and deficiencies identified in 1977 been fully and completely corrected? In addition, has the Central Office established satisfactory formalized specific criteria for evaluating the costs versus the benefits of contracts proposed by medical centers, and are those criteria used to evaluate each contract?

Mr. FURUKAWA. Well, it's quite clear to us that there is a need for data that can be used to evaluate proposed contracts prior to award. This workload data is essential in order to form a basis for assessing the reasonableness of the quantity of services to be obtained and the reasonableness of prices to be paid. Much of that information is lacking.

Mr. EVANS. Nowhere in your testimony did I find anything about the appearance of a possible or actual conflict of interest in the contracting process. When a VA employee who has a faculty appointment is involved in negotiating or administering a contract between the VA and that affiliated university, at the very least there is the appearance of a possible conflict of interest.

Can you tell us, in any of the VA medical centers in which scarce medical services contracts have been audited in the last 2½ years, if you could apply either term, to the manner in which a contract was awarded, administered, or funds paid to the contractor were utilized? Have you examined this issue of either actual or apparent conflict of interest and what implications it might have?

Mr. FURUKAWA. Yes, sir. To my knowledge there was one situation—in Palo Alto, I believe it was—where there appeared to be some question about a possible conflict of interest. The Chief of the Radiology Service, a full-time VA employee, also was one of the negotiators of the contract and served as a contracting officer's technical representative on the contract.

The IG investigators are looking into that case. To my knowledge it has not yet been finalized, and therefore I am not in a position to comment on it, much beyond that.

Mr. EVANS. That is the only instance in the last 2½ years or so that you have seen either an apparent—or perhaps, actual—problem of conflict of interest?

Mr. FURUKAWA. To my knowledge—perhaps Mr. Slachta might be able to expand on that.

Mr. SLACHTA. In our audit report of the VA medical center at Birmingham we did not find a conflict of interest situation, but we indicated that the Chief of Radiology Service should be removed from the position of technical representative. I believe it was the administrative assistant who was made the technical representative. We wanted to avoid the appearance of a conflict of interest.

Mr. EVANS. In the Palo Alto case, that case is still being looked at by the IG? And do you know when any report might be issued by the IG?

Mr. FURUKAWA. That, I do not know. I believe it must be getting close to finalization, but I can't say for certain.

Mr. EVANS. The new IG audit summarized audit activities at eight medical centers. Are the findings in the summary audit applicable only to these medical centers, or are these findings generally applicable? In other words, in your opinion, how widespread are the inadequacies and deficiencies that you've identified?

Mr. FURUKAWA. It's very difficult to say with any degree of certainty, but just the general nature of the findings indicate that they could very well exist in many other locations and in many other types of contracts.

Mr. EVANS. The $1.7 million that you estimate could be saved for only eight specific centers that were studied, just for those contracts?

Mr. FURUKAWA. That's correct.

Mr. EVANS. Are the IG's recommendations, then, for improving the award and administration of anesthesiology and radiology contracts also applicable to contracts for other medical services, in your opinion?

Mr. FURUKAWA. Yes, we believe they are.

Mr. EVANS. In several audits the IG has stated that contractors have been overpaid. For example, according to the IG the University of Miami was overpaid by about $480,000, and the University of Arkansas was overpaid by $232,000. The IG has also recommended recovery of excess contract payments. Can you tell us if these excess payments have been recovered, how much has the IG recommended for recovery, and how much has actually been recovered? What follow-up actions have been taken by the IG toward recovery of these overpayments?

Mr. FURUKAWA. I can't give you a precise figure as to how much we had recommended for recovery. And also, I am unable at this point to tell you how much has been recovered.

Mr. EVANS. Has some money been recovered, to your knowledge?

Mr. FURUKAWA. I believe some has, yes. And in the response to our cyclical audit reports, the medical center directors did indicate that they would initiate actions to recover payments in those cases where they felt it was appropriate.

We normally follow up on those actions when we go back on the next cyclical audit, which is normally on a 3-year cycle, and I don't believe we've followed up on these particular issues yet.

Mr. EVANS. We, of course, would be interested as you do follow up on those issues. If you could provide us both the amounts that the IG has recommended to be recovered as well as how much has

actually been recovered to, let's say, the date of this hearing. That would be very useful to us. Could you do that?

Mr. FURUKAWA. We'll be glad to do that. Yes, sir.

(See "Audit Findings Regarding Scarce Medical Specialists Contracts at Five Medical Centers" on p. 39).

Mr. EVANS. I do have more questions, but at this time I'd like to yield to the gentleman from Arizona.

Mr. STUMP. Thank you, Mr. Chairman.

You stated in your statements that contracts were awarded in both anesthesiology and radiology that were not needed. How do you determine the need at the various institutions?

Mr. FURUKAWA. Well, the way we determined need was by reviewing various surgical logs and other records maintained at the medical centers. It was apparent to us that the amount of services that we had contracted for exceeded the requirements, if you compared it to the workload at these various facilities.

One of the problems also in trying to pinpoint exactly how much was excessive and how much was really needed was that accurate records were not maintained in all cases when these physicians were actually physically present and performing their duties. In some cases they were performing other non-clinical duties, research-related activities, and so forth. But just based on the workload at a particular facility, the logs that were maintained, and by speaking to the officials at the medical centers, we reached certain conclusions regarding the extent to which services were needed.

Mr. STUMP. Are these part-time people, or do they fill in on other jobs when they're needed? Or are they just on call? I don't quite understand.

Mr. FURUKAWA. Well, for the most part, they are full-time. There are problems also with some of the contract provisions. The provisions generally require the physicians to be physically present and performing their duties. There are differing interpretations of this, however, and some people feel that if a physician is on standby or on call or available, that that would be sufficient to meet the requirements of the contract. We do not believe that to be the fact.

Mr. STUMP. You have not recommended that?

Mr. FURUKAWA. No, sir.

Mr. STUMP. You said that by the end of August, 1987, everything would be worked out. How do you intend to follow through on these to make sure that they are and are these on the 3-year cycle that you spoke of to the Chairman a while ago?

Mr. FURUKAWA. Well, on the cyclical audits, we follow up on the 3-year cycle. On the more major audits, the policy issues, we follow up more frequently. I would think that within 6 months after issuance of this report we will be checking with DM&S to see what actions have been taken, and monitor it on that basis.

Mr. STUMP. Thank you.

Mr. EVANS. I have a concern that I want to share with you. I am concerned about the follow-up which occurs after an audit is issued. Typically, the audit will contain a statement to the effect that "the planned actions are responsive to our recommendations and we consider all audit issues resolved." Well, 10 years ago an audit recommended that the VA Central Office needed to improve its process for evaluating and approving contracts proposed by medical

centers. Those process improvements still need to be made. We simply can't assume corrective action will be taken someday in the future. We need to know if those planned actions are actually taken. We need to know if the identified deficiencies and inadequacies have been in fact corrected, and we simply can't assume that all audit issues are resolved.

Now, I understand that you have, in the IG's Office, some 381 employees. We on the committee generally feel that would be sufficient resources to follow up on many of these issues. Would you have any response to this concern of our committee?

Mr. FURUKAWA. I would agree with you that we do have sufficient resources to follow up on these activities.

Mr. EVANS. All right.

Mr. FURUKAWA. I would like to point out that this previous audit that you refer to was done in 1977, before the establishment of the Inspector General's Office. Since that time, the Office of the IG has established formalized follow-up procedures, and I'm quite confident that on any major issue, any significant issue, we will follow up to see that the program managers have taken the actions that they promised to take in their implementation plans, and if not, we will bring it to the attention of appropriate officials.

Mr. EVANS. Your testimony states that the summary audit was issued to assure that the Chief Medical Director was aware of your findings. Was the Chief Medical Director not aware of IG audit findings until a summary audit was issued?

Mr. FURUKAWA. I cannot say that. He very well could have been familiar. But we do issue a lot of cyclical audit reports which contain a large number of findings. Whether or not all of these issues are brought to the attention of the Chief Medical Director, I cannot say. What we noticed was that this problem was recurring in a number of our reports. We recalled that we had issued a report some 10 years ago, and that it was probably appropriate at this time to make sure that it was brought to the attention of the Chief Medical Director, so that timely action could be taken.

Mr. EVANS. I think these audits imply a widespread need to improve the accuracy and adequacy of contractor time and attendance records. Has the IG issued specific recommendations on time and attendance records? Have those recommendations, if proposed, been adopted? And if not, what recommendations could you offer?

Mr. FURUKAWA. We have made recommendations to improve the recordkeeping for these contracts in selected locations. To my knowledge, we have not made an overall recommendation in the past to tighten up on the recordkeeping. But I believe it's something that DM&S is certainly well aware of at this point, and it's an action that I believe can be implemented without a whole lot of difficulty.

Mr. EVANS. Are you going to actually follow up on that, then?

Mr. FURUKAWA. Yes. We will follow up on all of the actions that we indicated need to be taken, and where DM&S has indicated to us that they do have a plan to implement our recommendations.

Mr. EVANS. Thank you.

Does the minority side have any questions?

Mr. DORNAN. Nothing, Mr. Chairman.

Mr. EVANS. Thank you, Ken, very much for your testimony. You held up very well today on your first appearance. I appreciate your time.

Mr. FURUKAWA. Thank you, sir.

Mr. EVANS. Our next witness is Dr. Daniel H. Winship. Dr. Winship is the Assistant Deputy Chief Medical Director for Operations and Programs with the Veterans' Administration. Doctor, will you and the witnesses who are accompanying you please come forward.

Dr. Winship, I understand that you have just recently assumed the responsibilities of your position, and that this is also your first opportunity to testify before the committee. We welcome you. We would like you to recognize and identify the officials that are with you here today for purposes of our record.

**STATEMENT OF DANIEL H. WINSHIP, M.D., ASSISTANT DEPUTY CHIEF MEDICAL DIRECTOR FOR PROGRAMS AND OPERATIONS, VETERANS' ADMINISTRATION; ACCOMPANIED BY: ROBERT E. LINDSEY, JR., DEPUTY TO THE ASSISTANT DEPUTY CHIEF MEDICAL OFFICER FOR PROGRAMS AND OPERATIONS; LAWRENCE B. HOBSON, M.D., DIRECTOR, EMERGENCY MANAGEMENT AND RESOURCE SHARING; DAVID DERR, ACTING DEPUTY DIRECTOR FOR PROCUREMENT SERVICES; AND RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL**

Dr. WINSHIP. With me are Mr. Robert Lindsey, who is Director of Operations; Dr. Lawrence Hobson, in charge of our Sharing Office; Mr. Ralph Ibson, Deputy Assistant General Counsel, and Mr. David Derr, Acting Deputy Director for Procurement Services.

Mr. EVANS. Thank you, Doctor. Your prepared statement was also previously submitted, which we appreciate, and without objection will appear in its entirety in the hearing record. You may summarize that statement, knowing that it has been submitted for the record, and proceed in whatever manner you wish.

Dr. WINSHIP. Thank you.

We appreciate the opportunity to appear before the subcommittee to discuss our sharing programs, particularly the acquisition of scarce medical specialist services. I would like to briefly discuss three different authorities that permit us to acquire or share medical services or resources.

First, section 4117 of title 38 allows the Veterans' Administration to enter into contractual arrangements that provide scarce needed medical services for veterans. With the enactment of Public Law 89-785 in 1966, the Congress recognized that increased specialization within the medical profession made it increasingly difficult for the VA to recruit all the highly specialized physicians required to render the best available clinical care to veterans. The intent was to allow the VA to obtain the best qualified medical specialists from the medical schools when they could not be recruited. Initially, other sources of specialists could be used only when a VA hospital had no medical school affiliation. Subsequent amendments broadened section 4117 to permit the VA to contract with others, including clinics and individuals, for the services of technicians and medical support personnel, as well as physicians.

Public Law 89-785 also provided authority for sharing of specialized medical services or resources between the VA and other institutions. In 1986, the VA spent about $37 million to obtain specialized medical resources. This was offset by almost $12 million that the VA received for services provided to sharing partners.

With the enactment of Public Law 97-174 in 1982, Congress encouraged the VA and the Department of Defense to share medical facilities as well as services. In 1986, the VA/DOD exchanges resulted in the VA paying almost $1 million for services rendered by the Department of Defense, and receiving $3 million for services VA provided to the Department of Defense.

All sharing arrangements combined supply a small portion of medical manpower for the VA facilities. The ability to enter into such arrangements, however, makes available to veterans clinical care that otherwise would be impossible or be more costly to obtain.

Although all sharing agreements are approved by VA Central Office management officials, each VA medical facility is responsible for administering the approved specialized medical resources sharing agreement, the scarce medical specialty contract, and the VA/DOD sharing agreement that it arranges. At present, the facility can renew a contract or agreement each year for no more than 4 years if there is no change in the services provided, and if the cost is not increased by more than 10 percent. The renewal contract or agreement is reviewed by the VA District Counsel, and then approved—if satisfactory—by the District Director for the medical facility.

The VA depends upon the Inspector General's audits and other routine program monitoring to evaluate performance under sharing agreements. At least every fifth year, the contract to be renewed must be submitted for review and reauthorization by the VA Central Office.

Anesthesiology and radiology account for a significant portion of scarce medical specialist contracts. Trained specialists in both fields are in short supply in some parts of the country, and the current income of anesthesiologists and radiologists in private practice generally far exceeds the VA salary scale. The Veterans Administration's Inspector General has just released an audit focused on the problems of contracting for these two scarce medical programs. The recommendations, which we agree with, include requiring the medical centers to improve the award and administration of anesthesiology and radiology contracts by defining the contract terms, ensuring that the contracting services do not exceed needs, and making certain that only services provided are paid for.

As we make improvements in these clinical and administrative areas, care will be taken to ensure that the corrective measures do not reduce the effectiveness of patient care.

Sharing programs provide a valuable element in providing quality clinical care in many situations. Like other programs, these programs can be improved, and the VA will follow the Inspector General's recommendations in order to improve program accountability.

Mr. Chairman, this concludes my statement. My colleagues and I will be pleased to respond to any questions that you or other members of the subcommittee may have.

[The prepared statement of Dr. Winship appears on p. 42.]

Mr. EVANS. All right, Doctor, thank you.

Knowing that you are new on board, maybe you can't answer this, but maybe someone accompanying you might be able to provide an answer. I had an earlier question for the IG panel about the 1977 internal audit. Some of the inadequacies and deficiencies identified in that audit have not been fully or completely corrected. The IG has just recently recommended that the Central Office establish formalized criteria for evaluating contract cost-effectiveness, apply consistent definitions to the contract terms, obtain copies of contracts and establish a follow-up system. And I think my question is obvious. How can these deficiencies still exist after 10 years? And how long will it take to correct them?

Dr. WINSHIP. If put in the context of what's been happening with the IG program and what's been happening with the contract program, the problem becomes a little clearer. The entire program of follow-up, which now is very much a part of the IG's regulations and a part of the IG's activity, was not in place 10 years ago nor did we have a special office administering the contracts program. I think we all can assure you that at the present time, with the kind of regulations and monitoring mechanisms that we have,and with a program office which was estblished within the last 5 years to follow the contracts, we will certainly be able to accomplish follow-up.

Mr. EVANS. Well, of course, we'll be taking a great interest in just how quickly this is implemented because we think that with the deficit we have to cut whatever waste exists in our budget. Certainly, when we're trying to provide the current level of services as we are, we're trying to get the most bang for the buck.

Dr. WINSHIP. And we certainly agree with that.

Mr. EVANS. Let me ask you about the possibility of an apparent or real conflict of interest in the contract process. I also asked this question to the IG. Does the fact that we have VA doctors who are also on the university faculty making contracts or administering them suggest to you a possible or real conflict of interest? Have you examined this issue at all?

Dr. WINSHIP. Certainly, it's a possible conflict of interest. But we have in place mechanisms to review of all contracts that come to the Central Office, even those that have a short turnaround in the field, to look at the potential for conflict of interest as one specific item. In fact, we have review by counsel to be sure that that's not the case.

You asked earlier about the situation, I believe, in Palo Alto as an apparent conflict of interest. That contract still is not signed, not agreed upon and signed, and that issue has been part of the reason. A proposed contract has been sent back and forth several times, which indicates we're very much aware of that as a possible factor.

Mr. EVANS. In the writing of contracts the counsel is looking into the possibility of a conflict of interest. We also have a potential conflict of interest, an apparent conflict of interest, in that these

same individuals, after the contracts are signed, sometimes administer these contracts. So just because legal counsel in the Veterans' Administration would sign off on the legality of the contract, we're worried about the performance of the contract as well. Is there any internal enforcement process or review process, I should say, designed to prevent conflict of interest in actual implementation or performance of those contracts?

Dr. WINSHIP. Yes, there is. The contracting officer or the person who is responsible for the administration of the contract must be someone who is not immediately hired by or paid by the contracting institution. Or, if there turns out to be a question, we simply require that the contracting officer be shifted, or the responsibility be shifted to someone who does not have that relationship with the contractor.

Mr. EVANS. In the Palo Alto case, is it a fact that while the contract is not signed, the services that were called for in that contract are being provided and are being paid for at the present time?

Dr. WINSHIP. Yes, that is correct. And they are being provided and paid for through a continuation of a mechanism which we have in place to be certain that, number one, the patients don't suffer, and number two, that we don't have a lapse of the activity, and that is why we are trying to negotiate an acceptable contract.

Mr. EVANS. Is that individual being paid in line with the same terms of that contract?

Dr. WINSHIP. I'm not certain of the exact terms of the extension of the purchase order, but the individuals are being paid, I understand, under a purchase order-kind of arrangement.

Mr. EVANS. We would appreciate information about the present terms of the purchase order.

Dr. WINSHIP. We would be glad to provide it in written supplement form.

[The information follows:]

TERMS OF PALO ALTO PURCHASE ORDER

The term of the purchase order was for the period October 1, 1986, through March 31, 1987. The monthly expenditure was $59,339.08 for 4.895 full-time equivalents. Stanford University furnishes the VA medical center with the services of 4.895 full-time equivalent anesthesiologists to perform necessary anesthesia services which include, but are not limited to, the following: (a) Preoperative evaluations of patients; (b) Administer anesthetics and conduct supportive therapy; (c) Undertake postoperative therapy referable to anesthesiology; (d) Furnish technical and/or professional direction of residents and interns employed by the VA; (e) Furnish consultations referable to anesthesiology; and (f) Emergency call services.

Mr. EVANS. All right. Let me yield to the gentleman from Arizona for questions that he may have.

Mr. STUMP. Thank you, Mr. Chairman.

Doctor, it appears that many of the problems described here today have existed for some time. Do you have confidence that the Central Office will follow through on contract changes to improve methods?

Dr. WINSHIP. I have absolute confidence that the Central Office will follow through. That's in my area of responsibility, and I'll see to it that it does.

Mr. STUMP. What do you think should be done with those people who have deliberately overcharged or misrepresented, or not followed through, on the contract?

Dr. WINSHIP. Well, I believe it's the responsibility of the medical center itself to deal effectively with those people and to better negotiate those contracts. In the case where overcharging has occurred in the past, a case-by-case review must take place with an analysis of each case bearing on the merits of that case; and then where overcharging is determined, that degree of overcharging then should be requested for reimbursement from the university or whoever the contracting group is.

Mr. STUMP. Do you think, then, that these people should be deleted from the list of those available?

Dr. WINSHIP. I don't think that's necessarily the case. First I would like to see the guidance that we are in the process of developing and sending to the field in terms of improved contracting methods and improved negotiation methods and improved management of contracts and monitoring of contracts—to determine that that really is effective— and if it is not effective, then we should consider other alternatives such as you mentioned.

Mr. STUMP. Will the DM&S circular mentioned by the Assistant IG be ready by the end of the month?

Dr. WINSHIP. It will be ready by the end of August. That directive requires that current copies of all contracts be sent in and provides guidance for the negotiation of contracts. Yes, those will be ready.

Mr. STUMP. I have no further questions, Mr. Chairman.

Mr. EVANS. Thank you.

With reference to the situation in Palo Alto, has the legal counsel for the VA ever refused to allow a contract to be signed, and is that present in any other situation in the VA at this time? In other words, are we using this purchase order mechanism elsewhere in the VA that you're aware of?

Dr. WINSHIP. Mr. Chairman, I don't have the data for the number of times that may have taken place. That is a mechanism which we have. We have the mechanism, and it's specifically for the purpose of keeping needed medical services from lapsing. We do have the mechanism of having a purchase order arrangement which is good for 90 days under which we can, for that short time, contract for needed medical services. And that is in place in a number of medical centers.

Mr. EVANS. All right. But not, maybe, as a result of a failure to sign a contract.

Dr. WINSHIP. I think there may be instances in which the parties cannot come to an agreement when extensions of that can take place. However, I think it's fair to say that whenever that goes on and on, we have to look at that each time the 90 days is renewed. We in the Central Office have to review such instances; and whenever that takes place, we become very concerned and attempt to get the parties to some sort of conclusion.

Mr. EVANS. In the Palo Alto instance, can you tell me how many times this particular purchase order has been renewed in lieu of the signed contract?

Dr. WINSHIP. I'm sorry, I don't have that specific information. I can provide that for you.

[Subsequently the Veterans' Administration provided the following information.]

PALO ALTO PURCHASE ORDER

One purchase order was issued by the Veterans Administration medical center, Palo Alto, California, to cover the period October 1, 1986, through March 31, 1987. Services beginning in April 1987 were provided under a full contract. The contract is effective from April 1, 1987, through March 31, 1988.

Mr. EVANS. It has been at least renewed several times?

Dr. WINSHIP. Yes, it has.

Mr. EVANS. I don't know if the IG has ever studied this particular mechanism. If we're having problems with written contracts, with terms that are specified for a period of time as compared to this 90-day purchase order mechanism, what is the impact? Do we know whether we have some of the same problems in the purchase order mechanism, maybe worse problems? You're saying that contracts are reviewed by legal counsel in the Central Office. My question is, if we don't have criteria to make sure that the terms of the contracts which we are reviewing today are good and that the implementation and administration of those contracts are what we would like, how can we know that the purchase order mechanism is any better or any worse than our current contracting procedure?

Dr. WINSHIP. Well, clearly the purchase order mechanism is not as good as the contracting procedure; otherwise we would use it in lieu of contracts. We don't do that. We want to go to the contract because that's a much more controllable situation for a longer period of time. And I will emphasize that it's only in times when we are sort of up against the wall, if you will, and cannot permit the lapse of patient care activities to take place that we're willing to go ahead and do that.

The scrutiny under which all of these procedures comes at the present time is really very close and very tight. The fact that we do not have a set of formalized criteria for all of these contracts can create a problem, of course, but I think you have to realize that each contract is tailored independently to the specific need that is extant at the medical center at a given time. Therefore, if the criteria are too rigid, they will give us a lot of difficulty in carrying out this contracting procedure. On the other hand, as far as radiology and anesthesiology are concerned, the criteria which we hope to develop in order to provide guidance to the field, will be coming about from the study that is going on in each one of those specific disciplines, one to be completed by September of 1988 and the other by September of 1989. We're very hopeful that by that time we'll be able to begin to fashion acceptable criteria which then can be used for the contracting mechanism. In the meantime, the guidance in terms of developing the contract will certainly proceed from our office; and even though very firm criteria are not in place at the present time, all of the contracts that come in are reviewed in the appropriate program office of the Central Office to be certain that it fits with acceptable practice and that overcharging is not taking place.

Mr. EVANS. I understand the Department of Medicine and Surgery plans to complete studies to develop these contract parameters for anesthesiologists and radiologists by September, 1988 and 1989, respectively. Those are the dates, correct?

Dr. WINSHIP. That's correct, yes.

Mr. EVANS. When will the contract parameters actually be developed and then finalized?

Dr. WINSHIP. Are you talking about from those studies?

Mr. EVANS. Yes.

Dr. WINSHIP. Those studies include the time of looking at what's going on the field and include the time of developing those parameters. We should have those by September, 1988 and 1989, respectively, for anesthesiology and radiology.

Mr. EVANS. They would be implemented at that time and actually be used?

Dr. WINSHIP. Yes.

Mr. EVANS. The IG reports that $53 million was spent in fiscal year 1986 by the VA to acquire resources through scarce medical specialist contracts and sharing agreements, but in response to a survey just conducted by this committee, 156 medical centers reported spending $62.9 million in fiscal year 1986 for service specialty contracts, excluding the VA/DOD sharing agreements. According to your testimony, about $25 million was spent in fiscal year 1986 to obtain scarce medical specialist services. Can you explain this substartial cost differences in the survey, the IG testimony and in your testimony?

Dr. WINSHIP. Our own sum is $63 million for all of those.

Mr. EVANS. Your own sum is $63 million?

Dr. WINSHIP. Yes.

Mr. EVANS. In your testimony you said $25 million.

Dr. WINSHIP. There are three different portions. There are contracts involving the mutual use or exchange of use of specialized Medical Resources, which is one portion; scarce medical specialist contracts, which is another portion; and then the sharing with DOD, which is another portion. And all those together should be $63 million.

Mr. EVANS. All right. Thank you for pointing that out to us.

Can you tell us a little more about your project to "share the purchase cost and the use of high-priced equipment"? How does this work? Where are the 14 VA medical centers and their sharing partners located? Are any of them close by?

Dr. WINSHIP. I can tell you about that, yes. Basically this is an initiative whereby we believe that we can get far more mileage out of our dollars by working out sharing arrangements with community centers, whether that be an academic medical center or some other kind of medical center. Those insitutions have made gifts to the VA of half of the cost of equipment. We purchase that equipment and develop an agreement for its mutual or shared use to cover the staffing and the operating costs and so forth. This has been very successful so far. We have gone through our first phase of that this past year. Mr. Robert Lindsey, Director of Operations, has been in charge of getting that operation up and running, and I would ask him to comment on that.

Mr. LINDSEY. There's not too much I can add to that, Mr. Chairman, except to say that this program has been looked upon with quite a bit of enthusiasm by both the VA and its sharing partners.

Dr. WINSHIP. Let me just add that Mr. Barry Bell, who is Director of the VA medical center at Portland and who is one of the panel, is one of those succes stories. I suspect he will be glad to comment on that.

Mr. EVANS. Can you tell us where any of these are located?

Dr. WINSHIP. Well, one is in Portland. Let me refer to Mr. Lindsey for the location of some of those.

Mr. LINDSEY. We can provide a list of those to you for the record. There are a number of locations now with that shared equipment across the country.

Mr. EVANS. Any close by to the Washington, D.C. area?

Mr. LINDSEY. Richmond, I believe.

[See "Locations with Shared Equipment," on p. 47.]

Mr. EVANS. Doctor, your testimony states, "Directives will be issued to request a current copy of all contracts that have been renewed by the medical facility for scarce medical resources and specialists." Can you tell us when the directives requesting submission of these contracts will be issued and when the contracts will be submitted?

Dr. WINSHIP. We already have that underway, Mr. Chairman. In the case of contracts that have been in place for up to 4 or even 5 years, if the contract doesn't change except for an increase in cost of not more than 10 percent, then they can be renewed locally. We have been reviewing those on about a 5-year basis, but we intend now to review those on a much more regular and much more frequent basis. We are in the process of sending a call for all of those to come in to Central Office; some of those have already come in, and we'll be reviewing all of those contracts over the next few months.

Mr. EVANS. Who is reviewing those contracts?

Dr. WINSHIP. Our Office of Emergency Management and Resource Sharing will be reviewing those.

Mr. EVANS. The purpose of the review is in light of the IG report?

Dr. WINSHIP. Exactly, yes.

Mr. EVANS. We're very concerned about some of your scarce medical specialty contracts. For example, in the IG audit of the anesthesiology contract at Palo Alto, the following appears on pages 2 and 3 of the audit: "In the past, DM&S officials have raised questions about the high cost of the arrangement with Stanford. For example, in fiscal year 1985 DM&S Surgical Service blocked the award of a contract because of the high cost. Because of this, VAMC Palo Alto purchased anesthesiology services from Stanford on a month-to-month basis. Total costs were approximately the same as they would have been under the proposed contract. However, they were not able to persuade Palo Alto management to negotiate a lower cost contract. When it became clear that the issue could not be easily resolved, the ACMD for Clinical Affairs reluctantly authorized Palo Alto to award the contract to Stanford."

The question is, who really makes these decisions? The Chief Medical Director's office? Each of the 172 medical center directors?

Or the affiliates? You say the office of the Chief Medical Director, but that is not what is stated in the Palo Alto audit, so it's unclear to us who makes these decisions.

Dr. WINSHIP. In fact, the contract in Palo Alto is not in force at the moment, so even though he may have reluctantly spoken to the medical center Director to do that, the contract is still not in force.

Mr. EVANS. It's not?

Dr. WINSHIP. The contract is not in force at the present time.

Mr. EVANS. It's not in force at the present time? Okay, it goes back to the purchase order issue, then. Does this mean that basically it's left up to the medical center Director?

Dr. WINSHIP. Well, the medical center Director, of course, has ultimate responsibility for the care of patients. We cannot take that responsibility in Washington for Palo Alto so that means that if it comes to the day when he does not have any kind of care, has no anesthesiologist to deliver that care to patients, then he's got to have a mechanism whereby he can do that. In the meantime, we need to work with him to determine—and help him determine—how is the best way to deal with that on a more long-term basis.

So immediately, yes, that is his responsibility. In the long term and in the oversight, that's our responsibility, and we take that.

Mr. EVANS. Page 6 of your prepared testimony contains a number of important statements. For example, "Guidance will also be provided to improve the negotiation of contract terms, specifications and requirements," and "more specific directions will guide contract administration to assure accountability of services received and payments made."

When will this guidance and direction be given? To whom? When will this direction and guidance be implemented?

Dr. WINSHIP. That guidance for the contracting arrangements, the technicalities of the contracting are really in the domain of our Office of Procurement and Supply. I'd like to refer that to Mr. Derr.

Mr. DERR. We have currently under consideration revitalized negotiation team concepts which would deal with the composition of the negotiating team, would assure that the lead responsible official for the contracting negotiation is, in fact, the contracting officer, someone who is not a medical specialist but a contracting officer. That official would also be immediately involved in cost and price analysis and those types of activities.

We are also expecting that the contracting officer technical representative designations would be made to those folks who are free of conflict, those folks who are not paid by the contracting institution—those folks in other areas of the health care facility on the Director's staff, or in some other area such as that.

We are also requiring that the contract file should include all of the cost information that was used during negotiations. Medicare rates, for example, have been considered, and that kind of information.

The Office of Procurement and Supply also has a training program for its contracting officers which leads, of course, to certification, and as a part of that training program we will be including classes relating to negotiation of scarce medical contracts.

Mr. EVANS. What's the status, then?

Mr. DERR. All of these issues are currently under development. It is not a long-term process. It should be something within a few months, early in the next fiscal year.

Mr. EVANS. Thank you.

Let me yield at this time to an active member of the committee and our colleague from California, Mr. Dornan, for any questions he might have.

Mr. DORNAN. No questions, Mr. Chairman.

Mr. EVANS. Okay, thank you.

Do you have any more questions?

Mr. STUMP. No, Mr. Chairman.

Mr. EVANS. Thank you again for your testimony. You also did very well your first time here, Dr. Winship. Thank you for coming, and thank you to the panel.

Dr. WINSHIP. Thank you.

Mr. EVANS. We may have some additional questions for you. They will be submitted to you in writing, and they'll be made part of the record, along with your answers. Thank you.

Mr. EVANS. Next is a panel of three medical center Directors. They are Dr. Wendell Musser, Mr. Barry Bell and Dr. Frank DeLand. If you gentlemen would please come forward, we would appreciate it.

Dr. Musser serves as Chief of Staff, Atlanta VA medical center. Mr. Bell is Director of the Portland VA medical center, and Dr. DeLand is Chief of Staff, Syracuse VA medical center. Thank you all for coming the distances that you have. We are interested in hearing your opinions on the issues that we are reviewing in the subcommittee today. You were not requested to submit a written statement in advance, but if you have a prepared statement it can be made a part of the record. If you want to summarize a prepared statement or read an entire statement, you may do so.

Dr. Musser, you may proceed whenever you are ready, and if you could limit your statement to 5 minutes that would be useful to the committee.

## STATEMENT OF A. WENDELL MUSSER, M.D., CHIEF OF STAFF, ATLANTA VA MEDICAL CENTER

Dr. MUSSER. Thank you, Mr. Chairman. It's a pleasure to be here again before this committee. I want to thank my Central Office superiors for their support.

I have great fear that we may take an essential element of the physiology of a very complex health care delivery system and address it in isolation. I would submit to you that that could do us great damage as far as putting together the matrix of services necessary to serve the veteran.

I think when we look at this complex situation we have to do like the health analysts, like Ann Somers recently published in the New England Journal of Medicine, to think of the overall goals of medical care in the United States, and that includes the Veterans' Administration Department of Medicine and Surgery—firstly, to enable people to stay healthy and functionally independent as long as possible; to provide access to good preventive short-term recuperative and rehabilitation services as needed; to encourage as much

patient autonomy and responsibility as possible, with care provided in the least restrictive and most cost-effective and appropriate environment and with continuity of management and records; and to encourage professional, educational, research, and financial activities and institutions essential to the attainment of those goals. If we don't reach for that sort of thing, we are falling short of the mark and not living up to our responsibilities.

Given the inherent complexity of those tasks—and I think that would be obvious to even the most casual observer—the hospitals and their environments and the overall expectations of society, it is little wonder that sometimes we fall short of the mark and we do not reach our goals.

Let me point out again, in our organization as well as in many in the private sector, an effective health care system depends upon the ability of the organization to adapt to that external environment; the ability of the organization to make the most appropriate use of the available resources, as this committee well knows; the ability to coordinate the interdependent roles and activities within the organization; the ability to solve or minimize tensions or conflicts within the organization; the ability to reach and maintain high levels of output; and finally, the ability of the organization to preserve its identity and basic character in the face of changes.

Whether one is responding to a statutory imperative, as you and I must do, or a regulatory directive, or a volitional choice of commitment, developing the matrix of services to care for the health of society or a portion of society as we do requires making judicious use of available resources. Inherent in our bureaucratic process of distribution of Federal resources is the realism that the demands placed on our agency mandate to care for the veteran population far exceed the resources distributed to the existing VA health care institutions. Space deficiencies, FTE and salary caps, funding deficiencies, and all the things you know about—especially difficulty in recruitment and retention—are all issues which limit our ability to meet the mandate of the agency.

It has been my experience that university medical education programs have more flexibility in generating the necessary resources to establish new programs, modernize existing programs and recruit and retain quality staff. Contracting for scarce medical specialty services or procuring medical procedures through mutual use or exchange of use contracting actions is a valuable means; in fact, in many areas of our country there is no other means of doing it.

Unfortunately, we have kind of a long history, ever since the Revolutionary War, and these fat DOD contracts that we deal with haven't helped most of our attitudinal stances towards the device of contracting. That's a shame, but it has occurred.

We must understand the vagaries of the contracting mechanism. We must understand that both contract and in-house costs increase over time due to wage adjustments. We should not be surprised when agency-initiated modifications necessitated by workloads or increases in new requirements or changing technology, etc., result in additional costs.

In my mind, there are ample instructions for contract development. There are specific work statements. There are valid monitoring criteria that are available. I think our failure, if it is failure, is

that we haven't found the mere mortals necessary to apply these and to successfully monitor the contract. With more diligence I think we can probably do that, and I think we heard that from Dr. Winship.

The arena which draws the most severe criticism is that unique interface between our VA medical centers and our affiliated universities and any contracts arising therefrom. It is inadequate to reduce the discussion to simplistic levels of supply and demand. There is a complex, commensal and mutually-supportive relationship necessary in order to fulfill the goals that we mentioned above for any health care delivery system, to encourage professional, educational, research, and financial activities to reach those goals, to repeat one of them.

It seems apparent to many of us that even in this arena, which is fraught with so many judgmental calls, that fair, just and equitable application of the present contracting rules will assist us in complying with the rules and at the same time reaching our service goals. We don't need more restricting and dehumanizing rules. We need men of good faith and judgment that understand the needs, the boundaries, and the final goals.

That's the conclusion of my formal comments.

[The prepared statement of Dr. Musser appears on p. 48.]

Mr. EVANS. Thank you, Doctor. We appreciate it.

Mr. Bell?

## STATEMENT OF BARRY L. BELL, DIRECTOR, PORTLAND VA MEDICAL CENTER, PORTLAND, OREGON

Mr. BELL. Thank you, Mr. Chairman.

What I would like to do today is present to you some information about what one medical center in the VA system is doing and how we're doing it.

I am the Director of the VA medical center in Portland, Oregon, a 670-bed tertiary care facility. I personally have been the director of three major, highly-affiliated tertiary medical centers over the last decade. During this time I have also been involved in agreements with affiliated universities for practically every kind of scarce medical services and resources that currently exist in the VA.

At the Portland VA medical center, shared medical services are an important part of the strategy that I use to provide a full range of services to the veteran patients we serve. Our affiliate is the Oregon Health Sciences University. We currently have and share with the university a jointly-purchased magnetic resonance imaging machine, costing $2.2 million, that was placed in operation July 1st of this year. We are now jointly purchasing a second—that is, two of the 17 that the VA has authorized so far—new linear accelerator at a cost of $2 million.

We also have some sharing activity in the areas of diagnostic radiology, clinical and anatomical pathology, cytogenetics, and ophthalmic services. We have major planning initiatives going on to combine our entire eye care services with the university, at the university, and to combine the University and VA clinical laborato-

ries at the VA. We are also looking at doing the university hospital's laundry at the VA.

My strategy, which is fully agreed-upon by all of the leaders at the University, is that the VA and the university can help each other significantly in many ways to achieve greater efficiency and provide improved quality of care. To do so, however, requires a partnership on an equal footing; and therefore, it is also part of that strategy that the goal is that each partner will provide approximately, in our medical center, 50 percent of the total value of the combined services, so that ideally there will be little money shift at the end of each year.

All activities are on a strict cost accounting system based on Medicare cost reports in which neither of us tries to make a profit at the expense of the other. The bases for my embarking on planning with the university on new shared services are two-fold. One, the VA can be more efficient doing it jointly, and can maintain the quality we expect. Secondly, when quality will be materially enhanced by joining with the university—such as in the eye care center program I just mentioned—we will join them on those bases.

As partners, the university and I have a very clear set of principles which the leadership of both institutions openly discussed and constantly remind our staff that they must be the premise for all sharing service agreements, and they are.

One, agreements must be fair to each party on their face as well as in fact. Good partnerships are hard to maintain if one party buys significantly more from the other, and therefore becomes at the mercy of unreasonable price increases; second, that the heads of the institutions must meet regularly to review and set the tone for all elements at both institutions; and lastly, all shared activities are developed to further the overall good of the university and the VA as a whole.

University departments and VA services may work out the details, but to be accepted by our joint management, they must further the overall working relationship of the university and the VA and not be based solely on the relative strengths or weaknesses of the department or the service involved. We view inappropriate advantages by either party in our area as detrimental to the overall VA-university relationship.

In summary, with health care dollars at a premium and with institutions that have many similar goals, it is foolhardy not to build a lasting, trusting relationship between VA medical centers and their affiliates. This saves taxpayers money, improves quality of care, and can enhance the quality of care available to veterans.

That's the end of my prepared remarks, Mr. Chairman. I am willing to answer any questions.

Mr. EVANS. All right, Mr. Bell. Thank you very much.

Dr. DeLand, please proceed.

**STATEMENT OF FRANK DE LAND, M.D., CHIEF OF STAFF, SYRACUSE VA MEDICAL CENTER, SYRACUSE, NEW YORK**

Dr. DELAND. Mr. Chairman, in reviewing several reports by the IG and reflecting back on negotiations that we have held for radiation therapy and diagnostic radiology, there appeared to me to be

certain common denominators that ran through most of these IG reports. And I thought that in view of our experience, which to date has been successful in negotiating, I thought I might list these common denominators as I see them from one who has to do the negotiating. As Dr. Musser says, we must provide the optimal level of diagnostic services with respect to expertise that is available and resources allotted.

Now, there are certain parameters that I saw in these reports and also encountered myself. Number one, the workload can be variable each day for a particular specialty. This translates into marked variation in unit productivity, and possibly, needless waste of resources.

Secondly, when you contract by FTE, although the contractual terms state that vacation time, sick leave, so on and so on, are the contractor's responsibility, realistically the contractor has to bill it into his contract, even if he has to do it in a sub-rosa fashion.

On an FTE basis, the verification of time spent by specialists on VA-related activities—such as clinical efforts, teaching, administration, research, consulting, and so on—is at best extremely difficult, extremely unsatisfactory, and frequently it is not productive with relationship to the duties required. That was a real common denominator I saw through all of these reports. The inequality of Federal salaries under title 38 compared to universities and private practice is extremely negative for recruitment, which demands then that we do a negotiation and recruit outside of the VA. For example, to make it very brief, a boarded pathologist who has just taken his boards would probably start at $83,000 at the VA; it would require that much, 15/5. For one with a bit of experience, he would be a 15/10 at $90,000. Comparably, in the university for 1986, taking the 80th percentile, which is about where radiologists are paid, an assistant professor, $119,000; associate professor, $147,000; full professor, $160,000. In private practice, $150,000 to $250,000, and I was talking to a man who runs a very outstanding radiology group of six in Louisville, Kentucky, at the best hospital in town. He was negotiating for a neuroradiologist. He had in mind a young man who was about 2 or 3 years out of his neuroradiology fellowship, with that bit of experience, which isn't extreme; but he anticipated that he would pay at least $200,000 to start.

So it is the inability to recruit excellent vascular, interventional and neuroradiologists at VA salaries that we encounter.

Now, here are certain guidelines I'd like to suggest that have occurred that really have helped us to a great extent.

Number one, to reimburse the scarce specialist by an agreed compensation per procedure and not on an FTE basis. FTE is really unrealistic.

Second, the VA station must collect, collate, and audit the work performed. For example, use the standard VA format for classifying procedures in diagnostic radiology. It's on the Ames Report of approximately 20 groups. Compute the value of these performances by the workload values of the procedure. The VA should do this, not the contractee.

Adjust the dollar equivalent for the workload values in relationship to the income of the locale. This can vary by 35 to 40 percent.

Specify the average professorial level of attendings in contracting with the affiliated universities. In other words, are you contracting for an average of two assistant and three associate professors? Then monitor it to make sure that that is what you get.

The service time obligation—this was another common denominator—the service time obligation for contracted physicians should be the same as for the VA physicians; that is, 24 hours a day, 365 days a year, with no extra compensation. And that seems to be quite acceptable on a procedure basis, rather than an FTE basis.

The attendings must be present when procedures are performed by a resident. This is a must.

As a sidelight—we haven't fulfilled this yet; we are still trying—but a full-time chief of radiology is highly desireable. That is a VA chief, full-time. But the sub-specialists I would never try to recruit because I don't think I can recruit them at the salary that we can offer and get the quality of man that I want. I'd much rather contract for the neuroradiologists, interventional radiologists, for vascular and cardiac radiologists, and so on.

Another recommendation that may help financially, if there were a way that we could place contracted physicians under the Tort Act, and thus eliminate the cost of malpractice insurance. Malpractice insurance is not too bad in affiliated universities, but if you have to contract with a private group, then, of course, it's terribly expensive.

In summary, we have completed a radiation therapy agreement, and our schedule is approximately 40 percent of that which the public pays. We have just completed the financial aspects of diagnostic radiology, and it appears that based on the way we're going to do it now, instead of the old FTE way, our costs will be about 35 percent of that of the public.

Thank you, Mr. Chairman.

Mr. EVANS. Well, thank you, Doctor. I want to thank the panel for responding in the way that you have. I think you offer some good critiques as well as suggestions on how we can do things better.

Mr. Bell, let me explore one issue with you. You mentioned equal footing between a VA medical center and an affiliate in contracting. How is that equal footing to be achieved and maintained?

Mr. BELL. Basically, every university and every medical center has a relative position vis-a-vis one or the other, whether the university is a rich university, a powerful university, and the VA is a big hospital with adequate resources, or whether it's a relatively poor hospital. And that footing comes about, basically, by matching up—looking at the relative strengths and weaknesses between those two facilities.

I've been in three, as I said. One was where the VA was dominant; one was where the university was dominant, and now lastly, I'm at one where we're equal in both our strengths and our weaknesses. And I think that is a major factor in the quality that the VA can use to deal with their affiliated universities.

Mr. EVANS. Well, it seems pretty promising, what you've described at Portland. Is this subject to an annual or a biannual review as to strengths and weaknesses and future needs? Do you continually assess?

Mr. BELL. Well, we are constantly assessing what new programs are coming out, what new modalities of care, what new technologies are coming out. We are also looking at both—I, at the VA, look at our long-range plans, construction plans, what our needs will be. The university has just recently done a new 10-year capital plan, and that was the result of them asking us if we would be willing to look at combining clinical laboratories. We have a brand new hospital which will be opened in about 6 months, and clinical laboratories are very equipment-oriented rather than labor-intensive, and a machine can frequently run double the number of tests without a lot of extra manpower. The university needed to spend close to $10 million for capital improvements, so they asked us if we would be willing to do that.

In the eye center, they are building a world-class eye center. Eye specialists are very, very difficult to obtain, and you need many, many different subspecialists in order to provide a full eye program. So we asked them if we could embark on moving lock, stock and barrel into that eye center as a partner under a sharing agreement.

Mr. EVANS. Thank you.

Dr. Musser, you're on the task force on RAM, I understand.

Dr. MUSSER. Yes, I am.

Mr. EVANS. That's a model for allocating resources within the various medical centers. Under RAM, VA medical centers that have scarce medical specialty contracts are allocated extra financial resources, recognizing the relatively high cost of these contracts. Could this be considered a negative incentive for the medical center to attempt to find more economical means of delivering medical care to veterans? We're interested in receiving your comments on this method of allocating financial resources and contract services.

Dr. MUSSER. If they were left unmonitored and untutored, as it were, and to go with reckless abandon, I suppose just the natural energy of the situation would create waste and let it go on. But that's not what we intend to have happen.

Any of the accounts that are passed through, and these would be, we would have those under scrutiny from the RAM overview aspect. We intend to advise the Chief Medical Director—and it is my impression that he intends to put in place—monitors, systems, constraints, restrictions, if I may, that would tend to reduce with each budget cycle the size and number of the pass-through accounts. We intend to introduce a data validation maneuver which we presently have under study and recommend it to the Chief Medical Director, and part of that would be reviewing these sorts of accounts.

Mr. EVANS. Does anyone else on the panel have a comment on that question or a concern about it?

Mr. BELL. Well, I always look at it, Mr. Chairman, that any money that goes out for contracts is coming out of our health care dollars, and every one of those are precious. Whether they are pass-through or non-pass-through, those are dollars that I use to care for veterans, and I'm not going to waste any of them if I can help it.

Mr. EVANS. Do any of you have an opinion about how we can avoid the appearance of possible conflict of interest, or actual conflict of interest, in the contract process that we've asked the two previous panels?

Dr. MUSSER. I'm surprised. I've been around long enough, and what little hair I have is turning white, almost as white as Ralph's—I was taught that the contracting officer is either the chief of supply or a stipulated individual within that service. And I find it disturbing if I find that is not the case. Within our regulations, within our tradition, within our history are ways of monitoring in making sure that there is full compliance with the laws and the regulations. It's there.

Now, I think that any individual who has an appearance of conflict of interest must be removed totally and immediately from those negotiations. I don't think there's any other choice. It isn't a matter of thinking about it; it's a matter of taking action and removing him. In this modern day, the appearance of conflict of interest is almost like being caught with a smoking gun, so we must avoid the appearance; and if there's appearance, you have to pull him out of the act.

As chief of staff, I certainly don't want to review the details. If someone asks my opinion of a pricing of a medical procedure, well, I can give an opinion; that's not being a contracting officer and not being responsible for these contracts.

Dr. DELAND. During our contractual talks—in contrast to what had occurred, I gather, previously—we insisted that the contracting officer do all the contracting in these two radiological fields, and that I served only as the technical adviser when they had a question, because I came from a radiological background. I didn't want that to appear like a conflict. But the officer in charge of contracts did all of the contracting.

Mr. BELL. What I'm used to as a process is that the chief of staff and I generally determine, in many different ways, what the relative need of our contracting situation is, and then set the guidelines for that in terms of how many dollars we have available, and stay fairly much involved with the process. We don't get down to the nitty-gritty of 27 pages of contract, but we set the parameters for that contract, the general dollars that we have available, what we want to get for those dollars. And in my current situation, I generally negotiate those to a large degree with the university myself.

Mr. EVANS. What about the possibility of conflict in the actual administration of the contracts? All your comments have focused basically on the negotiations leading to the signing. What about in actual implementation of the contract? We are concerned that payment for contract services has not been supported by documentation demonstrating that the services were actually provided. What can we do there, in your opinion, to deal with that apparent conflict of interest?

Dr. MUSSER. That's a management style problem. It's a management imperative that cannot be abrogated and must be fulfilled. To me, it's very simple. It's part of the job; and if you aren't doing it, you aren't doing the job.

There are all kinds of techniques, therefore. I utilize a member of my staff, the Associate chief of staff for ambulatory care, boarded internist, boarded in infectious disease, a reader of the manual. He actually enjoys it, which sometimes makes me wonder; but nonetheless, he is very expert. Every bill that comes back through goes across his desk. That may sound like a little bit of an overkill, but if it is in variance in any way to the contract, then it is investigated. The ones that are at great variance are brought directly up to my office because I am the liaison with the school, and I go figure out what went wrong. Why is this incredible thing happening? What is the justification for this variance that we see?

Now, that's simple management to me, and somebody in the top management triad has got to take the responsibility and be accountable therefor.

Mr. BELL. If I may add, Mr. Chairman, and I agree with Wendell, it has to be a local management issue because even if we just talk about anesthesiologists, if there are ten hospitals contracting for anesthesiologists, there will be ten different uses of those anesthesiologists within those ten hospitals. Some will be supervising residents. Some will be supervising nurse anesthetists. Some will be running intensive care units. Some will be coming in at midnight in order to cover patient emergencies in those areas. So you have to develop locally the implementation of how to control those based on how you're using anesthesiologists. That, I don't believe, could be done very well from the Central Office or through any other mechanism. That's a management issue, as Wendell said.

Mr. EVANS. Let me at this time yield to the gentleman from Arizona.

Mr. STUMP. No questions, Mr. Chairman.

Mr. EVANS. We want to thank you for the excellent testimony before us today and we appreciate your comments. We hope there are a few other people inspired to read the manuals and bills. Thank you very much for coming today. We appreciate it.

Our final witness today is Dr. Paul Schafer. Dr. Schafer is Executive Director of the National Association of VA Physicians. Doctor, if you will come forward at this time. You were also not requested to submit a written statement in advance of the hearing, but if you have a prepared statement we'll be glad to insert it into the record and it will be included in its entirety. You may feel free to either summarize that statement, give it in its totality, or proceed in any manner that you like. Thank you for joining us.

## STATEMENT OF PAUL W. SCHAFER, M.D., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS

Dr. SCHAFER. Thank you, Mr. Chairman, members of the committee. I am the full-time Chief of Thoracic Surgery at the Washington, D.C. VA medical center; however, I accept your invitation to appear here today in my strictly unofficial role as Executive Director of the National Association of VA physicians. My academic title is Georgetown University Professor of Surgery at the VA.

We are most appreciative of this opportunity to have NAVAP's position heard on this most important and very complex issue. We try to assess all such issues as our by-laws require, namely, what

best preserves and perfects the veterans' medical program and the interests of the physicians and the other health care workers who serve therein. Generally, we oppose the movement out of the program of any vital function, whether called "contracting-out," "sharing," "affiliation," "vouchering," "prospective payment," or whatever else. Sad will be the day when the power structure tries to implement recommendations that our facilities be given over to local community interests, or that they be operated as a GOCO.

Those in the agency's management leadership, in Central Office, in Region, in District, and in local facilities must be free from the possibility of conflict of interest or even the appearance thereof. Out-placement decisions dare not be held within a shroud of secrecy. They must become public knowledge and must be known as to their details and as to their effects. Anything less than full scrutiny in the light of day is no longer acceptable.

Most to be avoided are decisions made by VA personnel who receive monetary, titular, ownership or other emoluments from organizations and individuals with whom the agency is entering into contract or any other kind of agreement. Absent this exclusion, the fact or perception of conflict of interest is inevitable and unacceptable.

Such decisions cannot properly be matters for deliberation or recommendation by Deans' Committees as they are now constituted. This matter was discussed at length in hearings on bills which led to P.L. 96-330. NAVAP's position then and now is that such bodies should reflect equal partnership in their membership. P.L. 96-330, at the plea of a former Chief Medical Director, required republication of the "equal partnership" characteristics of Policy Memorandum No. 2 and stipulated "appropriate committee membership." Shortly after enactment of the law, the CMD issued a directive to the 172 VAMC's that the "appropriate" requirement of the law could mean as few as one full-time VA physician member. This is nothing less than a betrayal.

Matters such as the foregoing will come into even sharper focus as our high tech society produces more and more big ticket modalities across the whole spectrum of medical services, ranging from data processing through research and education to clinical diagnostics and therapeutics.

Over the years telephone calls and letters coming in to NAVAP headquarters have given us a unique opportunity to observe the evolution of some sad past events which it would serve all best interests to avoid in the future.

Mr. Chairman, that exhausts my allocated time; however, I am prepared to undertake answers to such questions as you may have, and I do thank you.

[The prepared statement of Dr. Schafer appears on p. 51.]

Mr. EVANS. Well, thank you, Dr. Schafer. We always enjoy having you before our committee. This is the first time I've had you before my subcommittee. Your colorful and articulate testimony is always welcome.

You have listened to the testimony and you are familiar with the findings of the IG audits concerning the contracts in question. Are there ways that the negotiation, the award, the administration of these contracts can be improved?

Dr. SCHAFER. I really don't feel great confidence in that kind of a technical question or an answer such as I might give you because my views always get down to individuals and the people who are affected—not just, as I said there, the patients themselves in the program, but the people who serve in the program.

I might give you an example which perhaps can be generic in the sense of, say, sharing agreements. We have just gone through the circumstance and the relationships between the Hinds VAMC and Loyola, wherein a sharing agreement was entered into with respect to the delivery of therapeutic nuclear services. I can tell you that this was largely precipitated by the desire on the part of the university to recruit a new chief in their Department of Radiation Therapy, which seems to me as only possibly valid as a basis for the dislocations that it occasioned at the affiliated VAMC.

I can tell you that the result is that the full-time, long-serving and loyal Federal employees, VA physicians, at the Hinds VAMC were told their services were no longer needed because "we're going to enter a sharing agreement; however, we've made arrangements for you to be employed by Loyola University. Now, of course, you will give up all your rights as Federal employees, but we encourage you to accept this employment."

The sharing agreement went forward; indeed, with great protest. We certainly joined in that protest, and the result is—I can tell you the track record of every single one of the VA physicians involved who were formerly members of the Hinds staff. Private practice appeared more favorable to them than the acceptance of the university position. One, if you can imagine, a radiation therapist, 12 years' service in the VA, is now working in the outpatient clinic. Another did accept the offer to go to Loyola and is very unhappy, but felt it was the only chance she could continue her professional practice.

That's a very limited answer, but it's in those terms that we become involved in regard to the effects of many of these arrangements which are not of the ideal high plain that our good friend, Barry Bell from Portland, has described.

Mr. EVANS. Well, that's interesting. That's a good example to use for this Chairman because that's in my native State, and we're concerned about the losses within the VA as a whole of those skilled and qualified people that have been, really, the hallmark of our system.

You heard Dr. Winship testify about the 17 special projects in the 14 VA medical centers being pursued to share the purchase cost and the use of high-priced equipment with their sharing partners. Are any of these projects at the VAMC in Washington, D.C.?

Dr. SCHAFER. Well again, Mr. Chairman, I am most reticent about the local VAMC. I feel much more comfortable when I'm talking about other VAMC's or about national issues because, after all, I am a full-time Chief of Thoracic Surgery at the Washington VAMC. I can tell you there is no secret about the distress that I felt and many of my colleagues felt when, at our annual meeting, our Chief of Staff announced that we had entered into a sharing agreement with George Washington University in regard to radiation diagnostics. This involved the purchase by the VA of an imaging apparatus, a nuclear magnetic resonance imaging apparatus.

I don't know the exact cost, but the tag usually is well in excess of $1 million; I think often perhaps as high as $2 million. And what distressed us was that the instrument is apparently to be located in George Washington University Hospital, which means that our sick VA patients will get the use of this instrument, for which we're paying, by being taken in an ambulance at all hours of the day and night across the city.

I think if the VA buys that kind of equipment, unless they are connected with the affiliated institution, the equipment should be placed in the VA medical center. It's for the veterans who we are supposed to serve and for whom we are supposed to spend our taxpayers' dollars.

Mr. EVANS. Is the price and cost of ambulance service for veterans figured in the contract?

Dr. SCHAFER. I have no idea about the specifics of the contract. I can only speak generally in respect to a concern which many of us on the staff feel very acutely. I do feel that very closely related to this is the point I made in my opening statement, that people who are involved in such negotiations just cannot be bearing administrative, academic, and management titles and be having their salary augmented, or in any other way be in a position where there may be no lack of innocence at all. But the appearance of conflict of interest can be very real.

Mr. EVANS. You've worked with individuals that belonged to your organization and you've given us some generic examples. Have you done an overall cost-benefit analysis of the losses of these jobs through contracting-out? Have you done any studies as an organization?

Dr. SCHAFER. No, we have not undertaken that. We don't have much of a staff and it's very difficult for us to undertake that kind of an evaluation.

What we do, though, we many times send out questionnaires to our members to try to get a feel of what's happening in respect to some specific problem; then, of course, our members are real live people who work in these medical centers, and they're involved in every aspect of the delivery of health care to veterans. We serve on systemic external review committees and SER's and all of those things, so we get exposure to the scene.

I would reinforce what Barry Bell told you about the circumstance of the strong and the weak and the equal members of a partnership. I think that has an enormous amount to do with the quality of the affiliation and the quality of the ultimate care that the veteran gets. When you have a very strong affiliated institution, a medical school, and you have a very weak medical center, our patients do not do well in that climate, and we have something very distinctly less than an equal partnership which is envisaged in this whole very, very desirable condition of affiliation. That's been the salvation of the veterans' medical program, is the fact that we have these effective affiliations. But by the same token, when they are not of that nature, we can do nothing but be critical of them. I have some affiliations with which I have great difficulty.

Mr. EVANS. Thank you for your advocacy for the physicians and also the patients in our system. We appreciate that very much.

Dr. SCHAFER. Thank you, sir.

Mr. EVANS. Mr. Stump?

Mr. STUMP. Nothing, thank you, Mr. Chairman.

Mr. EVANS. All right.

Doctor, thank you very much for your time today.

We want to thank all the witnesses for participating. This is an issue that we'll continue to monitor in this committee, and we'll be talking to some of the other members of our committee and the Chairman about some of the consequences we see. We hope that we can proceed within the VA and within the IG to work out some of the problems that we face.

Thank you all again. The hearing is concluded.

Whereupon, at 3:12 p.m., the subcommittee was adjourned.

# APPENDIX

STATEMENT OF

HONORABLE LANE EVANS, CHAIRMAN

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

WELCOME AND GOOD AFTERNOON. THE SUBJECT OF OUR HEARING TODAY IS CONTRACT MEDICAL SERVICES.

UNDER CURRENT LAW, THE VA MAY CONTRACT WITH HEALTH CARE PROVIDERS TO PURCHASE NEEDED MEDICAL SERVICES. BY USING CONTRACTS, VA MEDICAL CENTERS ARE ABLE TO PURCHASE SERVICES WHICH THEY OTHERWISE MIGHT NOT BE ABLE TO OBTAIN. IF A VA MEDICAL CENTER CANNOT RECRUIT OR RETAIN THE PERSONNEL NEEDED TO PROVIDE A PARTICULAR SERVICE, THAT SERVICE CAN BE PURCHASED BY CONTRACT. CONTRACTS FOR PURCHASING MEDICAL SERVICES ARE CLEARLY AN IMPORTANT RESOURCE.

THE COST OF MEDICAL SERVICES PURCHASED BY CONTRACT CAN ALSO BE SIGNIFICANT. ACCORDING TO THE VA INSPECTOR GENERAL, LAST FISCAL YEAR NEARLY $53 MILLION WAS SPENT TO ACQUIRE RESOURCES THROUGH SCARCE MEDICAL SPECIALIST CONTRACTS AND SHARING AGREEMENTS. BASED ON THE RESULTS OF A RECENT SURVEY CONDUCTED BY THE COMMITTEE, MORE THAN $62 MILLION WAS SPENT BY VA MEDICAL CENTERS LAST FISCAL YEAR TO PURCHASE CONTRACT MEDICAL SPECIALTY SERVICES.

SEVERAL PREVIOUS ROUTINE AUDITS ISSUED BY THE INSPECTOR GENERAL HAVE ADDRESSED THE SUBJECT OF CONTRACT MEDICAL SERVICES. MORE RECENTLY THE IG ISSUED A SUMMARY AUDIT ON THIS SUBJECT AS WELL. THESE AUDITS SUGGEST NOT ALL CONTRACTS FOR MEDICAL SERVICES HAVE BEEN NEGOTIATED, ADMINISTERED OR USED WISELY. THESE AUDITS CONTAIN A NUMBER OF DISTURBING FINDINGS AND THEY INDICATE THE POSSIBLE WASTE OF SUBSTANTIAL RESOURCES.

ACCORDING TO THE IG AUDITS:

(1) CONTRACTS HAVE BEEN NEGOTIATED AND ADMINISTERED BY PERSONS WHO HAD A PERSONAL FINANCIAL INTEREST IN THE CONTRACT;

(2) CONTRACTORS HAVE RECEIVED PAYMENT FOR SERVICES WHICH THEY DID NOT PROVIDE;

(3) CONTRACTORS USED OVERSTATED COST AND PRICING DATA TO JUSTIFY INFLATED AND EXCESSIVE CONTRACT COSTS;

(4) MORE SERVICES WERE PURCHASED THAN WERE NEEDED; AND

(5) NO INTERNAL CONTROLS WERE ESTABLISHED TO INSURE PROPER CONTRACT NEGOTIATION AND ADMINISTRATION.

AGAIN AND AGAIN, THESE AUDITS INDICATE CHANGES ARE NEEDED IN CONTRACTING FOR MEDICAL SERVICES. THE STATUS QUO IS NOT ACCEPTABLE TO THIS COMMITTEE.

THE CONTRACTS WHICH HAVE BEEN REVIEWED BY THE IG ARE AGREEMENTS BETWEEN A VA MEDICAL CENTER AND AN AFFILIATED MEDICAL COLLEGE OR ASSOCIATED INSTITUTION. THE PURPOSE OF THIS HEARING IS NOT TO EXAMINE THE POTENTIAL VALUE OF ANY PARTICULAR AFFILIATION OR AFFILIATION GENERALLY. AFFILIATION IS NOT THE SUBJECT OF THIS HEARING. THE SUBJECT OF THIS HEARING IS MEDICAL SERVICE CONTRACTS --- THE NATURE OF CONTRACT AGREEMENTS, THE CONTRACTING PROCESS, AND CONTRACT ADMINISTRATION.

IN ADDITION, WE WANT TO LEARN WHAT CORRECTIVE ACTIONS HAVE BEEN RECOMMENDED AND CAN BE TAKEN. WHAT CAN AND SHOULD BE DONE TO INSURE THAT RESOURCES ARE USED MORE WISELY AND EFFICIENTLY IN THE FUTURE?

STATEMENT OF KENNETH T. FURUKAWA

ASSISTANT INSPECTOR GENERAL FOR AUDITING

VETERANS ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

JULY 29, 1987

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our audits that reported on the VA's obtaining and providing medical services through contracts with affiliated medical schools.

Under the provisions of Title 38 U.S.C., the VA may contract with health care facilities to provide, share, or receive scarce medical services. Most of these contracts are between VA medical centers and their affiliated universities. In Fiscal Year 1986 the VA received services valued at about $53 million and provided about $10 million of medical services. The sharing or contracting for scarce medical resources is most prevalent in the following programs: radiology, anesthesiology, pathology, cardiac surgery, organ transplants and hemodialysis.

Our normal audit process requires the review of all VA health care facilities on a three-year cycle. Audits of VA medical centers are necessarily limited by available audit resources. As a result, we are not able to review all VA services and functions during each cyclical audit. Since sharing agreements and scarce medical services contracts are not a major resource issue at most VA medical centers, these contracts are not routinely subject to cyclical audit. However, during the last 2½ years we have issued six medical center reports that contained findings regarding the VA's purchase of medical resources from affiliated universities. In total, these six medical centers paid approximately $3.7 million for services of which we estimated that costs could be reduced by about $1.7 million (45%) through improving the contract award and administration process.

In order to assure that the Chief Medical Director was aware of our findings in the cyclical audits and of the potential for a developing Agencywide problem, we recently summarized our findings and made recommendations to improve overall accountability. Our summary audit detailed the following issues:

- Contracts were entered into for some anesthesiology and radiology services that were not needed and VA medical

centers paid for some services that were not provided in accordance with contract terms.

- Controls had not been established to ensure that services were required and contractor performance and billings complied with contract terms.

- In addition DM&S had not adequately developed a system for evaluating and monitoring the award of contracts.

In order to assist DM&S we recommended that the Chief Medical Director improve the award and administration of scarce medical resource contracts by (i) requiring medical centers to ensure that anesthesiology and radiology contracts include clearly defined contract terms and requirements and services contracted for do not exceed medical center needs, (ii) developing evaluative criteria, e.g., performance standards and workload data, for evaluating contract proposals, (iii) developing consistently applied definitions of what constitutes major and minor surgery and on-call coverage, and (iv) obtaining a copy of all current contracts in effect and establishing a followup system to ensure medical centers take appropriate action for contracts having contingency approval.

The Chief Medical Director concurred with our recommendations and indicated that the Department will publish a circular by the end of August 1987, which will request that field facilities send into VACO for review all renewed scarce medical contracts. In addition, DM&S plans to complete studies to develop contract parameters for anesthesiologists and radiologists by September 1988 and September 1989, respectively. According to the Chief Medical Director, these actions will enable the Department to develop a relationship between workload and FTEE requirements. The planned actions are responsive to our recommendations and thus, we considered all audit issues resolved.

This concludes my testimony, Mr. Chairman. I will be pleased to answer any questions you may have.

Office of Inspector General

Washington, D.C. 20420

Veterans Administration

SEP 8 1987

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In Reply Refer To 53B

Honorable Lane Evans
Chairman, Subcommittee on Investigations
and Oversight
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

At the July 29, 1987 hearing on VA's use of scarce medical specialist contracts, you requested that we provide the Subcommittee with the following information:

- the amount of accounts receivable establisned, bills of collection issued, and money collected as a result of our audits of scarce medical specialist contracts at VA Medical Centers (VAMC's) Palo Alto, Miami, Birmingham, West Haven, and Baltimore.

The total accounts receivable established and the amount collected was $34,129 by VAMC Birmingham. Generally, the problems identified in our audits at VAMC's Palo Alto, Miami, West Haven and Baltimore were: (i) contracting for more services than required, (ii) inadequate controls to ensure that services contracted for were provided, and (iii) misinterpretation of contract terms. Thus, resolution of these problems will not result in reimbursements to the VA for services already provided; however, we do expect future contract prices to be reduced. To more fully explain, we have enclosed a summary of the findings at the five medical centers, the recommendations made, and the actions taken or planned by medical center management.

If additional information is needed, please contact Jack Kroll, Assistant Inspector General for Policy, Planning and Resources, at 233-5297.

Sincerely,

Frank S. Sato

FRANK S. SATO
Inspector General

Enclosure

Enclosure

VA Inspector General Findings
Regarding Scarce Medical Specialist Contracts
at Five Medical Centers

VAMC Birmingham, AL

FINDING: The University of Alabama at Birmingnam was inappropriately paid an estimated $39,955 for interpretations of radiographic examinations read by VA-paid residents.

RECOMMENDATION: Recover overpayments made to the University of Alabama for radiographic interpretations.

ACTIONS TAKEN/PLANNED: The medical center conducted a 100% review of the interpretations completed during the period audited to determine the total overpayment amount. Based on the results of the review, an accounts receivable of $34,127.76 was established and this amount was subsequently collected by an offset against the amount that was due at the time to the University.

VAMC Miami, FL

FINDING: The anesthesiology and radiology contracts were not being effectively administered, due to differing interpretations of the contracts' terms by the medical center and university, and inadequate documentation by the medical center to verify services received. As a result, the university could have been overpaid between $115,900 and $479,000.

RECOMMENDATIONS: Issue a bill of collection for contract overpayments to the University of Miami School of Medicine and clarify the terms of the contracts.

ACTIONS TAKEN/PLANNED: The medical center director agreed to review the university's cost data and, based on this review, establish an appropriate bill of collection if indicated. The director subsequently reported that, after review of the contracts and discussion with the contracting parties, it was determined that the intent of the contracting parties for regular and special coverage was provided and a bill of collection was not indicated. The director also reported that the terms of the existing contracts had been clarified.

Enclosure

VAMC Palo Alto, CA

FINDING: The anesthesiology contract had not been properly negotiated nor had internal controls been established to insure contract services were provided. As a result, the contract staffing was more than was needed for the workload and payments were made for services that had not been provided.

RECOMMENDATIONS: Reduce contracted staffing by 2.4 FTEE physicians or to a level consistent with the projected FY 1987 clinical workload and establish internal controls to insure that future contracts are properly negotiated and administered.

ACTIONS TAKEN/PLANNED: The medical center director reduced staffing by 1.0 FTEE physician and reported that this staffing level was consistent with the projected FY 1987 clinical workload. The director also reported that the medical center was attempting to hire anesthesiologists at the VA salary scale to reduce the contract costs and had established controls to insure proper negotiation and administration of future anesthesiology contracts.

VAMC Baltimore, MD

FINDING: (A formal finding was not reported. Rather, the problems noted below were included in the audit report as a "Management Advisory Matter.")

Improved controls were needed to insure that contract radiographic and radiation therapy services were actually provided. There was no established method to record the staffing provided and time spent and payments appeared to have been made for radiation treatments that had not been provided.

RECOMMENDATION: Neither a formal finding nor a formal recommendation were reported because the medical center had converted the contracts to fee - for - service arrangements in an effort to improve accountability. The audit team was unable to evaluate the new agreements and associated controls because expenditures had not been made or reported. The management advisory section included a statement that the medical center should establish controls for the new agreements to document services provided and account for contract expenditures

ACTIONS TAKEN/PLANNED: The medical center director agreed to implement the suggested controls.

Enclosure

VAMC West Haven, CT

FINDING: Contract needs had not been accurately assessed nor had adequate controls been established to insure that therapeutic radiology, nuclear medicine, pathology, and diagnostic radiology services had been provided. As a result, staffing provided under the nuclear medicine and pathology contracts was excessive for the workload and payments were made for services that may not have been provided.

RECOMMENDATIONS: Reduce future contract staffing to reflect actual demand and establish a method to insure that contract services are provided.

ACTIONS TAKEN/PLANNED: The medical center director agreed to rewrite the new contracts to reflect actual needs, including FTEE where appropriate or defined workload where preferable. The director also reported that performance standards had been developed to measure contractors' performance and attendance and had been incorporated into the new contracts.

STATEMENT OF

DANIEL H. WINSHIP, M.D.

ASSISTANT DEPUTY CHIEF MEDICAL DIRECTOR

FOR OPERATIONS AND PROGRAMS

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

JULY 29, 1987

Mr. Chairman and Members of the Subcommittee:

We appreciate the opportunity to appear before the Subcommittee to discuss our sharing programs, particularly the acquisition of scarce medical specialist services.

Sharing Programs of the Veterans Administration

In 1966 Congress authorized the Veterans Administration to enter contractual arrangements that would provide needed scarce medical services for veterans (Public Law 89-785).

Congress recognized that increased specialization within the medical profession made it increasingly difficult for the VA to recruit all the highly specialized physicians required to render the best available clinical care to veterans. This law was also recognized as a means of enhancing VA-medical school relationships. The intent was to allow the VA to obtain the best qualified medical specialists from the medical schools when they could not be recruited. Initially other sources of specialists could be used only when a VA hospital had no medical school affiliation. Subsequent amendments broadened Section 4117 to permit the VA to contract with others, including clinics and individuals, for the services of technicians and medical support personnel as well as physicians. Section 4117 allows a contractor to include

as costs, collectable as part of the overall price, such expenses as mileage, malpractice insurance, sick leave, administrative costs and vacation time. The contracted services must be provided in the VA medical center and payments are limited to personal services and may not include supplies or equipment. In FY 1986 the VA spent about $25 million to obtain scarce medical specialist services.

Public Law 89-785 and subsequent amendments to Section 5053 of Title 38 provided for sharing of specialized medical services between the VA and other institutions. With the encouragement of the Appropriations Committees, the VA is piloting a special project using this authority to share the purchase cost and the use of high-priced equipment that is at the forefront of technology. To date we have funded 17 programs of advanced equipment for 14 VA medical centers and their sharing partners. It is too soon to evaluate the success of this initiative since the sharing agreements have been in operation less than a year, however, all indications point toward improved patient care in an economical manner. In 1986 the VA spent about $37 million to obtain specialized medical resources including this special initiative. This was offset by almost $12 million that the VA received for services provided to sharing partners.

Public Law 97-174 encouraged the VA and the Department of Defense to share medical facilities as well as services. In 1986 VA/DoD exchanges resulted in the VA's paying almost $1 million for services rendered by DoD and receiving $3 million for services provided to DoD. The VA/DoD sharing program has received a very helpful impetus from Chairman Sonny Montgomery. A noteworthy event occurred this past month in Albuquerque, New Mexico, when the joint VA/Air Force hospital admitted its first patients. There are other potential sites for such joint ventures with Armed Forces' health facilities and they are being actively explored. VA/DoD sharing activities are expected to continue to grow both in volume and scope of services shared. All sharing arrangements combined supply only a small portion of medical manpower for VA facilities. The ability to enter into such arrangements makes available to veterans clinical care that would otherwise be impossible or more costly to obtain. Some non-veteran patients, including DoD beneficiaries, also receive better medical care as a result of sharing but these arrangements cannot in any way reduce care for veterans.

Process of Development, Review and Approval of Sharing Agreements and Specialized Service Contracts

Pursuit of the various sharing programs involves several components of the Veterans Administration. An individual VA medical center or clinic originates the request for an agreement or contract, negotiates its terms, and requests approval by submitting it through management channels to the Emergency Management and Resource Sharing Service within our Department of Medicine and Surgery. This Service coordinates the review and approval of the proposed agreement. This includes obtaining (1) an evaluation of the need for the service or facility from the Regional Director involved; (2) an evaluation of the soundness of the proposal and the reasonableness of the charges from the relevant VACO Clinical Service or Services; (3) a technical review of the quality of the contract from the Procurement and Supply Service: and (4) a review of the legality of the arrangement from the General Counsel's office. Following these evaluations, the proposal is considered by a multi-service committee that can recommend approval, disapproval or modification of the proposed arrangement. Final approval is by the Director for Operations.

Each VA medical facility is responsible for administering the approved specialized medical resources sharing agreement, scarce medical speciality contract, and VA/DoD sharing agreement that it arranges. At present, the facility can renew a contract or agreement each year for no more than four years if there is no change in the services provided and the cost does not increase by more than 10 percent. The renewal contract or agreement is reviewed by the VA District Counsel and then approved, if satisfactory, by the District Director for the medical facility.

The VA depends upon the Inspector General's audits and other routine program monitoring to determine the quality of performance under sharing agreements. At least every fifth year, the contract to be renewed must be submitted for review and reauthorization by the VA Central Office.

Effects of Sharing

There is little doubt that the various sharing arrangements have improved the quality of care in VA medical facilities, as the Congress hoped they would. For example, contracting for computer-assisted tomography, cardiovascular surgery, and transplantations have made clinical services available to veterans that would otherwise be impossible to obtain. This is also true with respect to anesthesiology and radiology in some locations.

These two clinical specialties account for a significant portion of scarce medical specialist contracts. Trained specialists in both fields are in short supply in some parts of the country and the current income of anesthesiologists and radiologists in private practice generally far exceeds the VA salary scale. During FY 1986 the cost of these specialist services reached $11.5 million for radiology, radiotherapy, and radiation physics, and exceeded $5 million for anesthesiology. Most of the large contracts are in VA medical centers affiliated with medical schools, in part because these large VA centers deliver tertiary or advanced care, and in part because they are usually located in areas of high professional incomes. It is in such locations and in such specialties that costs are increasing most rapidly.

Problems of Contracting for Scarce Specialists' Services

The Veterans Administration's Inspector General has investigated the problems arising from the high cost of these two scarce medical programs, namely anesthesiology and radiology. The Department of Medicine and Surgery does not agree with all of the analysis included in the Inspector General's report but does concur with the recommendations.

The recommendations include requiring the medical centers "to improve the award and administration of anesthesiology and radiology contracts" by defining the contract terms, ensuring that the contracted services do not exceed needs, and making certain that only services provided are paid for. The report also recommends that VA Central Office improve the evaluation of contracts by formalizing criteria for cost-effectiveness, applying consistent definitions of contract terms, obtaining copies of current contracts, and establishing a follow-up system for contracts with contingency approval.

To implement the recommendations directives will be issued to request a current copy of all contracts that have been renewed by the medical facility for scarce medical resources and specialists. Guidance will also be provided to improve the negotiation of contract terms, specifications and requirements. More specific directions will guide contract administration to assure accountability of services received and payments made. As a long range initiative, a study of anesthesiology contracting is already underway to improve further the negotiating and administration of contracts in this specialty. A similar study of radiology contracting will be initiated to improve performance as well. As we make improvements in these clinical areas and others, care will be taken to ensure that the corrective measures do not reduce the effectiveness of patient care.

Sharing programs provide a valuable element in providing quality clinical care in many situations. Like other programs, these programs can be improved and the VA will follow the Inspector General's recommendations in order to improve program accountability.

Mr. Chairman, this concludes my formal testimony. My colleagues and I will be pleased to respond to any questions you or other members of the Subcommittee may have.

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* Magnetic Resonance Imaging (MRI)

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*** Computer Assisted Tomography

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## PREPARED STATEMENT OF DR. A. WENDELL MUSSER

Mr. Chairman, Members of the Committee, Central Office VA officials and ladies and gentlemen, it gives me great pleasure to be allowed to make these few remarks about contracting for services in the Department of Medicine and Surgery of the Veterans Administration.

Many, such as Somers, have suggested that the overall goals of medical care in the United States ought to be: (1) to enable people to stay healthy and functionally independent as long as possible; (2) to provide access to good preventive, short-term, recuperative, and rehabilitative services as needed; (3) to encourage as much patient autonomy and responsibility as possible, with care provided in the least restrictive and most cost-effective and appropriate environment and with continuity of management and records; and (4) to encourage professional, educational, research, and financial activities and institutions essential to all of these goals.

Given the inherent complexity of the tasks, the hospitals and their environment, and the overal expectations of society, is it any wonder that we sometimes fall short of our goals? An effective health care system depends upon: (1) the ability of the organization to adapt to the external environment; (2) the ability of the organization to make the most appropriate use of available resources; (3) the ability to coordinate the interdependent roles and activities within the organization; (4) the ability of the system to integrate members to develop common organizational values and shared norms, attitudes and mutual understandings; (5) the ability to solve or minimize tensions/conflicts within the organization; (6) the ability to reach and maintain high levels of output; and finally (7) the ability of the

organization to preserve its identity and basic character in the face of changes, which are constantly occurring in the environment and within the system.

Whether one is responding to a statuatory imperative, a rejulatory directive, or a volitional choice of commitment, developing the matrix of services to care for the health of society or a portion of society requires making judicious use of available resources. Inherent in our bureaucratic process of distribution of federal resources is the realism that the demands placed on our agency mandate to care for the vetern population far exceeds the resources distributed to the existing VA health care institutions. Space deficiencies, FTE and salary caps, funding deficiencies and difficulty in recruitment and retention of qualified professional health care providers are all issues which limit our ability to meet the mandate of the agency. It has been my experience that university medical education programs have more flexibility in generating the necessary resources to establish new programs, modernize existing programs and recruit and retain quality staff. Contracting for scarce medical specialist services or procuring medical procedures through mutual use or exchange of use contracting actions is a valuable means of gaining access to the affiliated institution's wealth of medical resources. Usually, although not always, our contractual agreements represent buying of university hospital services since it has been my experiences that these institutions are better able acquire new resources. In many areas of our country, contracting may be the only or at least the cheapest method available for securing the services needed. Unfortunately, there is a long and redolent history of government contracting, from Revolutionary War scandals right up to some of today's bloated defense contracts. Many times our behavior has been

found wanting. We submit that there is little need for additional legislation or regulation, but just understanding and application of present laws and regulations. We must understand some of the vagaries of the contracting mechanisms. We must understand that both contract and in-house costs increase over time due to wage adjustments. We should not be surprised when agency-initiated modifications necessitated by workload, increases new requirements, etc., result in additional costs whether the function is performed by contractor or government personnel At present there are ample instructions for contract development, specific performance work statements, and valid monitoring of approved criteria. It may be that we have not been as successful as we should have been in finding mere mortals to apply these criteria and to successfully monitor the contracts. With more diligence we can probably do that.

The arena which probably draws the most severe criticism is that unique interface between our V.A. Medical Centers and our affiliated universities and any contracts arising therefrom. It is inadequate to reduce the discussion to a simplistic level of supply and demand. There is a complex, commensal and mutually supportive relationship necessary in order to fulfill the goal mentioned previously, to encourage professional, educational, research, and financial activities necessary to reach all goals. It seems apparent to many of us that even in this arena which is fraught with so many judgmental calls that fair, just and equitable application of the present contracting rules will assist us in complying with rules and at the same time reaching our service goals.

We don't need more restricting and dehumanizing rules. We need men of good faith and judgment that understand the needs, the boundaries, and the final goals.

# Dr. Paul W. Schafer

NATIONAL ASSOCIATION OF VA PHYSICIANS

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X Robert A. Middleton, M.D.
Dallas, TX

XI Clifton R. White, Jr., M.D.
Portland, OR

XII Cyril Berman, M.D.
Los Angeles, CA

Mr. Chairman, Members of the Committee, my name is Paul W. Schafer, M.D. I am the full-time Chief of Thoracic Surgery at the Washington, D.C. VA Medical Center; however, I accept your invitation to appear here today in my strictly unofficial role as Executive Director of the National Association of VA Physicians (NAVAP). My academic title is Georgetown University Professor of Surgery at the VA.

We are most appreciative of this opportunity to have NAVAP's position heard on this most important and complex issue. We try to assess all such issues, as our By-Laws require; namely, what best preserves and perfects the Veterans Medical Program and the interests of the physicians and other health care workers who serve therein. Generally we oppose the movement out of the Program of any vital function, whether called: Contracting Out, Sharing, Affiliation, Vouchering, Prospective Payment, or whatever else. Sad will be the day when the power structure tries to implement recommendations that our facilities be given over to local community enterprises or that they be operated as a GOCO (Government Owned-Commercially Operated).

Those in the Agency's management leadership, in Central Office, in Region, District, and in Local Facilities must be free from the possibility of Conflict of Interest or even the appearance thereof. Out-placement decisions dare not be held within a shroud of secrecy. They must become public knowledge and must be know as to their details and as to their effects. Anything less than full scrutiny in the light of day is no longer acceptable.

Most to be avoided are decisions made by VA personnel who receive monetary, titular, ownership, or other emoluments from organizations and individuals with whom the Agency is entering into contract or other agreement. Absence this exclusion, the fact or perception of Conflict of Interest is inevitable and unacceptable.

Such decisions cannot properly be matters for deliberation or recommendation . by Deans Committees as they are now constituted. This matter was discussed at length in Hearings on Bills which led to P.L. 96-330. NAVAP's position then and now is that such bodies, should reflect Equal partnership in their membership. P.L. 96-330, at the plea of a former Chief Medical Director, required republication of the equal Partnership of Policy Memorandum #2 and stipulated "appropriate" Committee membership. Shortly after enactment of the law the CMD issued a directive to the 172 VAMC's that the "appropriate" requirement of the law could mean as few as one full-time VA physician member. This is nothing less than a betrayal.

Matters such as the foregoing will come into even sharper focus as our high tech society produces more and more big ticket modalities across the whole spectrum of medical services ranging from data processing through research and education to clinical diagnostics and therapeutics.

Over the years telephone calls and letters coming into the NAVAP Headquarters have given us a unique opportunity to observe the evolution of some sad past events which it would serve all best interests to avoid in the future.

That exhausts my allocated time; however, I am prepared to undertake answers to such questions as you may have.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

NOV 12 1987

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans'
Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Agency's responses to the questions which were submitted following the July 29, 1987, hearing by the Subcommittee on Oversight and Investigations by Representative Lane Evans, Chairman of the Subcommittee. I apologize for the delay in providing these responses.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

cc: Chairman, Lane Evans

# WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CONGRESSMAN EVANS

QUESTION: 1. The prepared testimony submitted by Dr. Winship stated that the Department of Medicine and Surgery concurs with the recommendations contained in the Inspector General's report (Report No. 7AM-A99-089), but the Department does not agree with all of the analysis which this report provides. Can you explain this statement?

ANSWER: The Department of Medicine and Surgery concurs with the recommendations; however, exhibits in the report analyzing workload were sometimes based on erroneous data reporting, misinterpretation of reporting instructions, and input errors by VAMCs. For example, the extremely wide range in the "average annual cost per patient" for radiation therapy arises because the "annual patient workload" was reported only for new patients by some hospitals and for each treatment of all its patients by others. The former, with a small number of new patients, would show a high "average cost per patient;" the latter, with a much larger number of treatments, each counted as a patient would have a much lower "average cost per patient."

QUESTION: 2. Will the recommendations which the VA Inspector General has recently made for improving the award and administration of anesthesiology and radiology contracts also be applied to contracts for other medical services?

ANSWER: They will be applied wherever it is feasible and cost-effective to do so. In some situations, where the only means of securing an essential medical service is by contract and where there is only one potential contractor, for example, it may not be possible to adhere strictly to the recommended procedures regarding contract award. We intend to emphasize to our medical centers their responsibilities for sound contract administration, consistent with the Inspector General's position.

QUESTION: 3. In several audits, the Inspector General has stated that contractors have been overpaid. For example, according to the IG, the University of Miami was overpaid by $480,000 and the University of Arkansas was overpaid by $232,000. The IG has recommended recovery of excess contract payments. Have these excess payments been recovered? How much of the total amount recommended by the IG for recovery has actually been recovered? How much has the Department attempted to recover and what actions were taken to recover these overpayments?

ANSWER: After careful review of these matters, the VA medical centers in question determined that "recovery" action was not warranted. At the VAMC Miami, the cognizant clinical service and top management have concluded that the payments made were not excessive. A review of the wording of the contract statement of work revealed that it did not describe adequately and specifically the characteristics of the work to be accomplished, nor specify the parameters, criteria, and standards by which the completed tasks or products were to be measured. The work which was performed was judged by the VAMC to have been entirely satisfactory and fully met the expectations for timeliness, and met the generally accepted standards of professional scope/level of performance even though these had not been individually identified as being critical and necessary components or qualities. In the view of the professional services of direct interest, i.e., Anesthesiology and Radiology, the fees charged by the contracting group at the University of Miami were well within the reasonable limits of fees charged in the community for such services. In any case, clear consensus at the VAMC held that the indefinite terminology employed in pertinent contract provisions would not support pursuit of any claim alleging overpayment.

QUESTION: 4. According to testimony presented to the Subcommittee by the Office of the Inspector General, the $3.7 million cost of purchasing contract services from affiliated universities by six medical centers could have been reduced by $1.7 million or about 45% through improved contract award and administration process. Do you accept these findings? If not, why not?

ANSWER: DM&S cannot accept the figure of $1.7 million as the savings that could have been effected by improved contract award and administration. DM&S agrees that improvements in the contracting process will result in reducing costs in some future contracts, but we believe that the 45 percent estimated by the IG is overstated. For example, VAMC Palo Alto agreed that the FY 87 contract could be reduced by 1 FTEE at an average annual cost avoidance of $172,000, but not the recommended 2.4 FTEE reduction ($410,000). Also, just as a VAMC could avoid cost if its staffing situation made it unnecessary to contract for specialized medical services, it could conceivably produce significant cost avoidance if staffing capabilities permitted greater ongoing scrutiny of contract administration. We trust that local medical center management is in the best position to weigh the cost effectiveness of such efforts.

QUESTION: 5. The IG audits have implied a widespread need to improve the accuracy and adequacy of contractor time and attendance records. What can the Department of Medicine and Surgery do to improve the accuracy and adequacy of contractor time and attendance records?

ANSWER: VA policy calls for our medical centers to maintain adequate, accurate records of contractor employees' time and attendance in providing services at VAMCs. We will certainly aim to reinforce that policy.

QUESTION: 6. Please provide the Subcommittee with a complete report on the current status of the special project to share the purchase cost and use of high-priced equipment referred to in your prepared testimony. (a) Please identify the 14 VA medical centers for which advanced equipment programs have been funded, (b) the sharing partner for each VAMC, (c) the equipment to be obtained and (d) the cost (purchase price) for each of the 17 programs, (e) the amount of each purchase price paid for by the VA, (f) the installation location of the equipment to be obtained for each project (VAMC or sharing partner) and any other information which you believe would be useful to the Subcommittee.

ANSWER: The numbers of projects and the VA medical centers involved were erroneously reported. Eleven proposals from ten VA medical centers and their sharing partners were approved for funding from the $10 million allocated to this program in FY 1986. The following table provides data required.

Three additional proposals were approved in principle but with deferred funding authority pending anticipated availability of FY 1987 funding. The FY 1987 program is expected to include 7 projects from as many VA medical center/non-Federal health care facility partnerships. Final negotiations for equipment procurement and terms of sharing agreements which will govern operation of the resultant clinical capabilities are to be completed early in November 1987.

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QUESTION: 7. If not provided in response to Question 6, please furnish the Subcommittee with details of the Washington VAMC-George Washington University Hospital nuclear magnetic resonance imaging project mentioned during the hearing. What are the responsibilities and obligations of each party according to the agreement governing this project? What is the acquisition cost of this equipment and what is the total cost of the project? How much of the acquisition and total project costs will be provided by the VA? Where will this equipment be located and how will it be used?

ANSWER: This project was ultimately not carried out because of difficulties George Washington University experienced in its efforts to secure a certificate of need for the equipment (which was to have been located at George Washington University). The specific responsibilities and financial obligations devolving upon each party would have been spelled out in a Mutual Use or Exchange of Use Agreement. The estimated equipment acquisition installation cost was $2.552 million, with the VA expected to pay 50% or $1.276 million of that amount. The equipment was to have been used in part to service VA patient needs for Magnetic Resonance Imaging under contract.